STUDY OF SUICIDE PREVENTION

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SUMMARY OF RECOMMENDATIONS

STUDY OF SUICIDE PREVENTION

This summary presents the recommendations approved by the Legislative Commission's Subcommittee to Study Suicide Prevention. The Subcommittee submits the following proposals for consideration by the 72nd Session of the Nevada Legislature:

RECOMMENDATIONS FOR LEGISLATIVE MEASURES - SUBCOMMITTEE BILL DRAFT REQUESTS (BDRS) FOR BILLS OR RESOLUTIONS

1. Draft and enact legislation requiring the development of a Nevada State Suicide Prevention Plan and establishing a Statewide Suicide Prevention Program within the Director's Office of Nevada's Department of Human Resources (DHR). The purpose of the state plan/program is to reduce the number of attempted and completed suicides in Nevada. The state plan should address the risk factors related to suicide and identify populations most at risk, and it should be distributed statewide and made available to the public not later than January 3, 2005.

The State Suicide Prevention Plan shall be modeled after existing state plans in Georgia and several other states, which incorporate goals from the United States Surgeon General's 2001 report, *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Nevada's state plan should focus on the Surgeon General's goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who are the first contacts with individuals at risk of suicide.

The Statewide Suicide Prevention Program will include the establishment and funding of two personnel positions to develop and implement suicide prevention programs in Nevada. One position would be the Statewide Suicide Prevention Coordinator based in the Director's Office of DHR in Carson City, and the other position would be a Suicide Prevention Trainer & Networking Facilitator based in the office of a government or nonprofit agency in Clark County. Funding for these positions may depend on a combination of government (federal, state, and local) and nongovernmental money. The Governor is urged to include this program as part of the DHR budget, and the Legislature is urged to approve a budget to support the program.

The Director of DHR shall be required to submit a copy of the state plan and a report on the program to the Governor and the Director of the Legislative Counsel Bureau (for distribution to the Legislature) on or before January 3, 2005.

Statewide Suicide Prevention Coordinator

Under the direction of the Director of DHR, the Statewide Suicide Prevention Coordinator will be responsible for developing, disseminating, and implementing a statewide suicide awareness and prevention plan and program throughout Nevada, including public education activities, gatekeeper training, and enhancement of crisis services. The Coordinator will conduct suicide prevention public awareness and media campaigns in all 17 Nevada counties, beginning first in Clark County.

Furthermore, the Coordinator will link suicide assessment and intervention trainers to schools, community centers, nursing homes, and other facilities serving persons most at risk of suicide. The position will coordinate the establishment of local advisory groups in each county to offer additional support to the program's efforts. Working with suicide prevention advocacy groups, community coalitions, managers of existing nationally accredited/certified crisis hotlines, and staff of mental health agencies in the state, the Coordinator will identify and address the barriers that interfere with providing services to at-risk groups, such as the elderly, Native Americans, youth, and residents of rural communities. The Coordinator will also develop and maintain a state suicide prevention Internet Web site with links to appropriate resource documents, accredited/certified suicide hotlines, licensed professionals, state and local mental health agencies, and national organizations.

The Coordinator will review current research on data collection for factors related to suicide, and develop recommendations for improved surveillance systems and uniform data collection. In addition, the position will develop and submit proposals for funding from federal government agencies and nongovernmental organizations. Finally, the Coordinator would provide oversight and technical assistance to the Suicide Prevention Trainer & Networking Facilitator based in Clark County.

Suicide Prevention Trainer & Networking Facilitator

Under the oversight of the Statewide Suicide Prevention Coordinator, the Suicide Prevention Trainer & Networking Facilitator will assist in disseminating and implementing the state suicide prevention plan and program in Clark County. This position will provide suicide prevention information and training to mental health agencies, social service agencies, churches, public health clinics, school districts, law enforcement agencies, emergency medical personnel, health care providers, and various community organizations. In addition, the position will assist in developing and carrying out public awareness and media campaigns targeting Clark County groups at risk of suicide.

The Trainer & Facilitator will assist in developing a network of community-based suicide prevention programs in Clark County, including the establishment of one or more local suicide prevention advisory groups. This position will facilitate sharing information

and consensus building among multiple constituent groups in the county, including public agencies, community organizations, suicide prevention advocacy groups, mental health providers, and various representatives of the at-risk population groups.

(BDR 40--288)

2. **Urge, by drafting and adopting a resolution, governmental and nongovernmental agencies in Clark County to cooperate in establishing a Clark County suicide prevention program to provide effective and diverse suicide prevention programs for its communities. Funding for these programs should include a combination of government (federal, state, and local) and nongovernmental money. The proposed suicide prevention program would include the following:**

   - **Evidence-based programs to reduce risk factors and enhance protective factors for suicidal behavior across the life span of individuals;**
   - **Distribution of awareness and educational materials to reduce the stigma associated with suicide;**
   - **A 24-hour suicide hotline accredited or certified by a nationally recognized organization in the field of suicide prevention (and supported by a continuation and increase in the Clark County local governments' existing funding for suicide prevention programs);**
   - **Service referral for at-risk individuals;**
   - **Development of a Clark County Resource Directory and/or Internet Web site for suicide prevention and survivor assistance;**
   - **Effective and accessible suicide intervention training for gatekeepers and first responders, including school district personnel;**
   - **Media education and guideline distribution; and**
   - **Suicide survivor services.**

   (BDR R--289)

3. **Urge, by drafting and adopting a resolution, that each community in Nevada form a coalition of agencies and service providers to address suicide prevention, education, response, and treatment (adapted to community resources and needs), with the goals of reducing suicides in each community and providing survivor support. (BDR R--291)**

4. **Urge, by drafting and adopting a resolution, that the Clark County Health District: (1) plan and coordinate a public information campaign on suicide prevention; and (2) expand community injury prevention efforts and increase the corresponding financial commitment. (BDR R--290)**

RECOMMENDATIONS FOR POSSIBLE LEGISLATIVE ACTIONS OR MEASURES TO BE CONSIDERED BY OTHER LEGISLATIVE COMMITTEES

5. Draft and send a letter to the Legislative Committee on Education recommending that it consider requesting legislation requiring all public school teachers, including elementary education teachers, to complete certain courses in suicide prevention prior to license renewal. Such legislation could require that Nevada's Regional Training Programs for the Professional Development of Teachers and Administrators provide teachers and administrators with information and training specific to suicide issues, including identifying and intervening with pupils at high risk of suicide.

6. Draft and send a letter to the Legislative Committee on Education requesting that it consider requesting legislation for an appropriation of state funds to provide additional counseling positions in public middle schools and high schools, and state funds for counselors at the elementary school level.

7. Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues recommending consideration of requesting that the Governor and the Legislature approve increased funding for mental health services throughout Nevada and particularly for rural mental health agencies to provide emergency response and ongoing services to suicide survivors, those who have attempted or threatened suicide, and those determined to be at high risk for suicide.

8. Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues requesting consideration of the following recommendations from the Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition:

- **Allow more people in crisis to have access to treatment and allow first responders, police, fire, and paramedics, a timely return to service by: (1) creating a centralized drop-off location for triage with funding provided by state and local governments and area hospitals; (2) developing a mechanism for providing permanent, long-term funding to support CPI and mental health services such as increasing the tax on the sale of liquor; (3) considering changing NRS 433A.330, which requires the mentally ill to be transported to hospitals for medical screening or authorize paramedics to transport patients, who meet specific criteria, directly to a Mental Health and Developmental Services (MHDS) facility or other qualified facilities for treatment; and (4) funding mobile crisis units that can make assessments in the field and reduce the need for transporting patients to hospitals.**

- **Increase services to the seriously mentally ill in southern Nevada by (1) adding sufficient crisis observation beds and adequate staff to care for the increasing number of patients who need mental health care, including those with co-occurring disorders; (2) adding sufficient in-patient beds and staffing for treatment after patients have been assessed and stabilized at a triage facility, emergency room, or MHDS facility; (3) establishing a client data base to provide easy access to available services, track patients through various programs and prevent duplication of services; (4) providing centralized and coordinated case management and outpatient services; (5) contracting with the Program for Assertive Community Treatment to perform personalized, intensive case management; and (6) ensuring that all possible federal funding has been accessed.**

- **Establish and fund a mental health court in southern Nevada.**

The letters from the Subcommittee should also include a statement in support of providing funding for mental health courts in northern Nevada and throughout the state.

9. **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of requesting legislation to amend the statutes pertaining to minors and alcohol. Although current law makes it unlawful for a minor to be purchasing, consuming, or possessing an alcoholic beverage, testimony indicated that law enforcement cannot arrest minors who have already consumed, but are not at the time consuming, an alcoholic beverage. Amend the statutes with provisions similar to the Reno Municipal Code whereby it is unlawful for a person under the age of 21 to "be impaired to any degree by the use of an alcoholic beverage." The purpose of this amendment is to require that such minors be required to undergo evaluation and possible treatment for alcohol and/or drug abuse.**

10. **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of the recommendation from the Task Force on Emergency Room Overcrowding (also known as the CPI Task Force) and the Southern Nevada Mental Health Coalition requesting legislation to expand the civil protective custody statute (NRS 458.270) to pertain to persons with substance abuse and mental illness.**

STATEMENTS TO BE INCLUDED IN THE SUBCOMMITTEE'S FINAL REPORT

11. **Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature approve the necessary state funding to provide MHDS with the computer equipment and related software necessary to collect and analyze data regarding suicide rates for MHDS clients and their family members.**

12. **Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature support state funding for the Reno Crisis Call Center to establish, in Clark County, a service similar to its existing crisis call center and suicide prevention hotline.**

13. **Include a statement in the Subcommittee's final report recommending that the Board of Regents of the University and Community College System of Nevada (UCCSN), the UCCSN Chancellor, and the President of the University of Nevada, Las Vegas (UNLV) assist in providing university faculty, staff, and students to help coordinate and staff suicide prevention programs in Clark County.**

One possible plan would be to coordinate educational, survivor support, and crisis line services through the Psychology Department at UNLV. A faculty member could serve in a coordinating role, responsible for overseeing the various support programs and supervising graduate students who would provide direct services. Services provided by graduate students could include educational programming for gatekeepers, at-risk groups and concerned community members, support groups for survivors, and coverage for the suicide crisis line. Additionally, graduate students could recruit volunteers from the community and from the undergraduate psychology program who would be trained to provide crisis intervention services and would assist with the crisis line work. Crisis line training and coverage would be specifically developed to meet accreditation/certification requirements with a short-term goal of obtaining crisis line accreditation/certification. This plan would provide continuity of preventative and intervention services as well as provide long-term stability in the delivery of ongoing services.

14. **Include a statement in the Subcommittee's final report recommending enhancing community gatekeepers' education and training by requiring two hours of continuing education in suicide prevention, including identification, diagnosis, referral, and treatment, as a requirement for renewal of license for health care professionals.**

15. **Include a statement in the Subcommittee's final report recommending that the DHR Health Division's Emergency Medical Services Program develop a formalized education and training program in suicide prevention for emergency medical services (EMS) managers and personnel. Among other things, the program should raise awareness of EMS personnel at risk for suicide. In addition, the program should provide EMS personnel with a directory of suicide prevention agencies and programs to leave at scenes of trauma.**

16. **Include a statement in the Subcommittee's final report recommending that Nevada school districts address adolescent suicide by adherence to a theoretical framework which incorporates three levels of intervention: (1) primary intervention – when a suicide occurs; (2) secondary intervention – treatment activity with survivors, other students, parents, school personnel, and so forth; and (3) tertiary intervention – suicide prevention activities and programs.**

In addition, recommend that the school districts consider hiring additional trained professionals, including counselors, school psychologists, and social workers, to: (1) conduct assessments, implementation, follow-up, and to provide treatment (including primary, secondary, and tertiary interventions); (2) perform interventions in school settings; (3) establish relationships with parents, students, and other professionals; (4) maintain effective networks with the community; (5) address the mental health of troubled students; and (6) support the school student services staff.

17. **Include a statement in the Subcommittee's final report recognizing the importance of including substance abuse and other co-occurring disorders in a Nevada statewide suicide prevention plan. In addition, the statement should recognize that the enhancement of the delivery of co-occurring treatment and services may assist in reducing Nevada's suicide rate.**

18. **Include a statement in the Subcommittee's final report recognizing that any state suicide prevention program should address the relationship between youth suicide and the use of alcohol and drugs by minors.**

19. **Include a statement in the Subcommittee's final report supporting the work of the President's New Freedom Commission on Mental Health. Also include in the final report a summary of the Commission's findings and recommendations regarding suicide prevention.**

REPORT TO THE 72nd SESSION OF THE NEVADA LEGISLATURE BY THE LEGISLATIVE COMMISSION'S SUBCOMMITTEE TO STUDY SUICIDE PREVENTION

I. INTRODUCTION

The Legislative Commission, at its meeting on September 6, 2001, created an interim subcommittee, comprised of four Senators and four Assembly members, to study suicide prevention in Nevada.

The following legislators served on the Subcommittee:

Senator Ann O'Connell, Chairwoman
Senator Randolph J. Townsend
Senator Valerie Wiener
Senator Mark Amodei
Assemblyman David E. Humke
Assemblyman David R. Parks
Assemblywoman Sheila Leslie
Assemblywoman Debbie Smith

Legislative Counsel Bureau (LCB) staff services for the Subcommittee were provided by Donald O. Williams, Chief Principal Research Analyst, and Kennedy, Senior Research Secretary, of the Research Division; and Jan K. Needham, Principal Deputy Legislative Counsel, of the Legal Division.

The Subcommittee held a total of five meetings, including the final meeting and work session, during the course of the study. Except for a meeting held in Reno, these public hearings were conducted through simultaneous videoconferences between legislative meeting rooms at the Legislative Building in Carson City and the Grant Sawyer State Office Building in Las Vegas.

During the course of this interim study, the Subcommittee obtained extensive expert and public testimony concerning Nevada's high rate of suicide, which has been the highest rate of any state in the nation, and the need for effective suicide prevention programs. It received testimony and correspondence from concerned citizens, clergy, educators, surviving family members of suicide victims, national and local suicide prevention advocates, medical researchers, licensed health care providers, law enforcement officials, emergency and fire service personnel, retired persons, and representatives from various public health and mental health agencies. Federal, state, and local officials contributed significant information and suggestions throughout the study.

At its final meeting and work session, the Subcommittee adopted 19 recommendations, including four bill draft requests (BDRs), for consideration by the 2003 Legislature. The recommendations address the following major topics:

- Developing and Implementing a Nevada State Suicide Prevention Plan and Program;
- Improving Local Suicide Prevention Services;
- Enhancing Suicide Prevention Education and Training for Key Gatekeepers;
- Addressing Suicide Prevention in Public Schools;
- Increasing State Mental Health Services; and
- Recognizing the Relationship of Substance Abuse and Other Co-Occurring Disorders to Suicide.

In this document, the Subcommittee has attempted to present its findings and recommendations in a concise form. A great amount of data was gathered during this study, and much of the information was provided in exhibits that became part of the minutes of the Subcommittee's meetings. All supporting documents and minutes of meetings are on file with the Research Library of the LCB. Additional Subcommittee information may be available on the Nevada Legislature's Internet Web site: www.leg.state.nv.us.

The Subcommittee recognizes the important contributions made to its study by the following persons (among many others):

Linda L Flatt, Community Organizer, Suicide Prevention Action Network USA (SPAN-USA)
Misty Allen, Crisis Line Coordinator, Crisis Call Center, Reno
Cindy Marchant, Suicide Prevention Network of Douglas County, Gardnerville
Jeanne Palmer and Mike Bernstein, Health Education Department, Clark County Health District
Carlos Brandenburg, Ph.D., Administrator, Division of Mental Health & Developmental Services
Michael J. Willden, Director, Nevada's Department of Human Resources

II. SUICIDE IN NEVADA AND THE UNITED STATES

The Subcommittee appointed by the Legislative Commission was directed to conduct a study of suicide prevention in Nevada and report its findings and recommendations. The following sections discuss the problems and issues identified by the Subcommittee.

A. PROBLEMS AND ACTIONS RELATING TO SUICIDE IN NEVADA

For many years, Nevada has ranked among the states with the highest rates of suicide and is

usually ranked first. It has consistently maintained a rate more than twice the national average.

1. Legislative Actions

Recognizing the seriousness of the state's suicide problem and the personal toll it has taken on the surviving family members, friends, and the community as a whole, the Nevada Legislature in recent sessions has attempted to address the problem. The 1999 Legislature adopted Senate Concurrent Resolution No. 11 (File No. 107, *Statutes of Nevada 1999*), which expresses the Legislature's support for community-based efforts for suicide prevention and treatment as well as programs for families and others who have lost someone to suicide. The resolution also encourages the development and promotion of related mental health services to assist persons at risk of suicide.

The 1999 Legislature also approved state funding for a statewide suicide prevention hotline. Section 18 of Senate Bill 560 (Chapter 544, *Statutes of Nevada 1999*) appropriated $200,000 over the 1999-2001 biennium from the State General Fund to Nevada's Division of Mental Health and Developmental Services (MHDS) to contract with community-based agencies to provide enhanced suicide hotline services and expanded suicide hotline services statewide. The 2001 Legislature continued this funding for hotline services by appropriating $100,000 each year of the 2001-2003 biennium under the MHDS budget.

The 2001 Legislature also considered Senate Concurrent Resolution No. 3, which would have directed the Legislative Commission to appoint an interim committee to study the problem of suicide and the feasibility of creating a statewide strategy to prevent suicide. Although S.C.R. 3 was adopted in the Senate, it was one of the measures unexpectedly delayed in the Assembly when time ran out at the end of the regular session. Recognizing that a majority of the members of both houses of the Legislature supported creating such an interim study, the Legislative Commission, at its meeting on September 6, 2001, created the interim Subcommittee to Study Suicide Prevention. The Subcommittee was given a rather broad mandate—to study suicide prevention—and was not limited to the provisions that were included in S.C.R. 3.

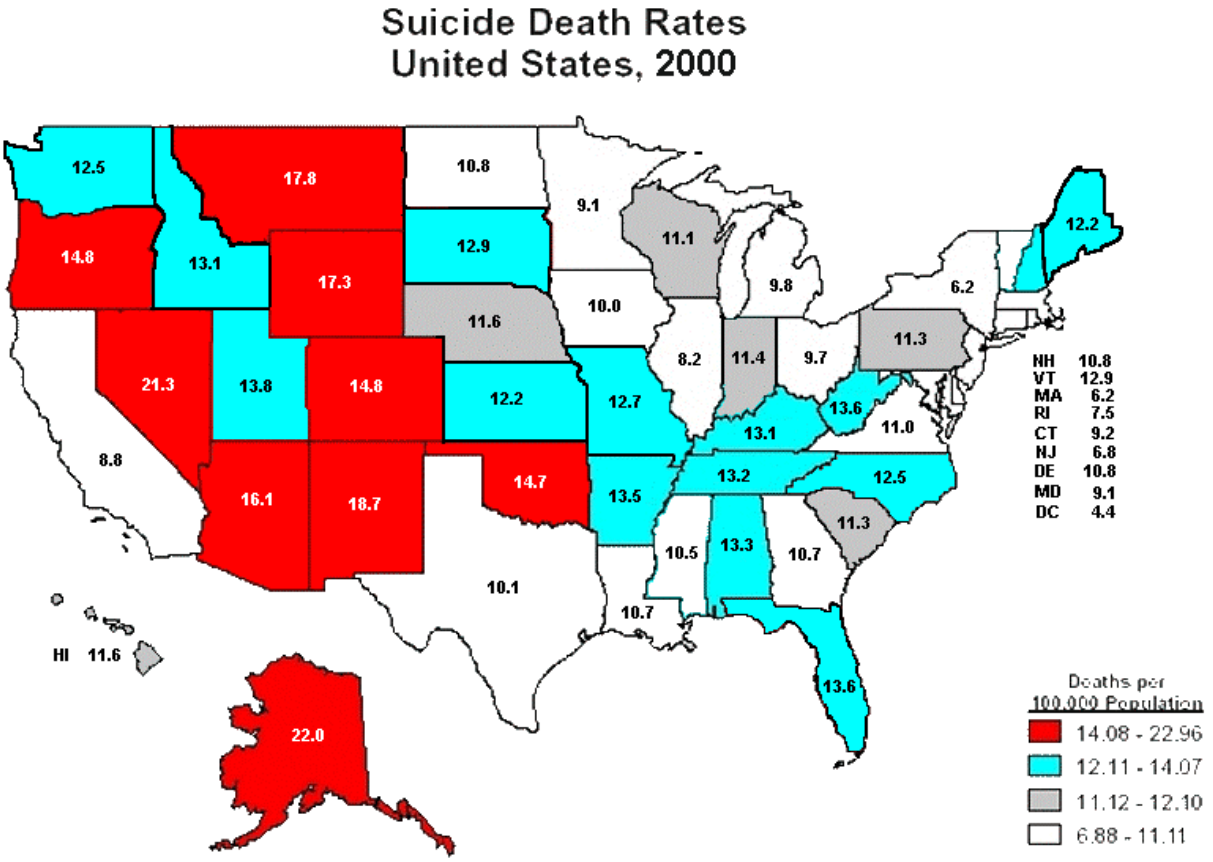
2. Problems Identified by Subcommittee

a. Nevada's High Rate of Suicide

The most recent rankings of suicide rates among the states are for 1998/1999 and 1999/2000. In 1998/1999, Nevada was reported to have a suicide rate of 22.3 per 100,000 population, the highest rate among the 50 states, as compared with the national state average rate of 10.7. In the most recent rankings (1999/2000), Nevada was reported to have a suicide rate of 21.3 per 100,000 population, second only to Alaska, as compared with the national average rate of 10.7.[1]

[1] "Rate, Number, and Ranking of Suicide for Each U.S.A. State*, 2000," by American Association of Suicidology, September 21, 2002, suicide state data page: 2000. (*Including the District of Columbia.)

Figure 1
Suicide Prevention Action Network USA



During its interim study, the Subcommittee discovered that the national and state research indicates Nevada's high rate of suicide is evident among all age groups and socio-economic populations in the state, including youth, elderly men, Native Americans, and residents of rural communities. This same research consistently has found that the vast majority of suicide victims are residents of Nevada and **not** tourists.

At its meeting in Las Vegas on November 9, 2001, the Subcommittee received a presentation of suicide statistics from a lead researcher of the federally funded suicide prevention research center based in Las Vegas. John Fildes, M.D., Chief of the Division of Trauma and Critical Care in the Department of Surgery at the University of Nevada School of Medicine in Las Vegas, made the presentation. He is also Co-Investigator of the Suicide Prevention Research Center, which is funded by the federal Centers for Disease Control and Prevention to study suicide in the intermountain western states.

Dr. Fildes presented the Subcommittee with the following suicide statistics and related information:

- For many years, Nevada has had the highest rate of suicide in the nation. Rate is defined as the number of suicides per 100,000 population. During the years of 1994 through 1998, Nevada's suicide rate averaged 21.8 per 100,000 population, while the national average rate was 10.8. Theories that Nevada's access to gambling may account for the high percentage rate are discounted because New Jersey (the second oldest state with legalized gambling) has one of the lowest suicide rates.

- Eight of the top ten suicide rated states are located in the intermountain West and have been in the top ten for the past 15 to 20 years, demonstrating that Nevada's neighboring states share high suicide rates as well. It is not clear why western states tend to have higher suicide rates.

- Unique features of the intermountain western states include a high Native American population, rural settings, lack of access to health care issues, population densities, different health care and mental heath care programming, and a cultural overlay (the personality of individuals in the intermountain west may be different).

- The leading causes of death in Nevada include (highest ranked first): (1) heart disease; (2) cancer; (3) pulmonary disease; (4) stroke; and (5) suicide. There are more suicide deaths than deaths from diabetes, motor vehicle crashes, liver disease, kidney disease, and infection. Nevada has twice as many suicides as homicides and Human Immunodeficiency Virus (HIV)-related deaths. There are four times as many suicides as deaths from Alzheimer's disease.

- Methods of completed suicides in Nevada include (highest ranked first): (1) firearms; (2) ingestions/poisoning; and (3) suffocation or asphyxiation. Firearms are the main method of suicide for youth and the elderly. Most suicide victims in the general population were male and used firearms.

- Information on suicide deaths is distilled from death certificates and vital statistics records. Suicides rates by ethnicity for the past five years are (highest ranked first): (1) Native American at 24.2; (2) White (includes Mexican and Puerto Rican) at 22.8; (3) Black at 13.7; and (4) Asian at 9.8.

- The total population of individuals who completed suicide as stratified by age indicates persons in their 20s, 30s, and 40s have the highest occurrence of suicides;

- The total population of individuals who completed suicide as stratified by age indicates that the phenomenon predominates in men. The rate of suicide for men aged 60 through 80 years is astronomically high considering the fewer numbers of individuals in this age category due to death by natural causes;

- The rate of suicide deaths by counties in Nevada shows that smaller counties by population (such as White Pine, Esmeralda, and Eureka) had higher rates than larger counties (Clark and Washoe).

- Statistics indicate that Nevada is not a "destination state" for suicides. In 1995, there were 435 suicides and the majority of the death certificates listed Nevada as the state of residency. In 1995, there were 50 deaths by suicide of non-Nevadans (of those 50 victims, 66 percent died in Clark County and 14 percent died in Washoe County). Additionally, 90 percent of completed suicides in Las Vegas had death certificates that listed that city as the victim's registered residency (Reno had 89 percent).

See Appendix A for more recent suicide statistics presented in an updated report (December 2002) from Dr. Fildes and the Suicide Prevention Research Center.

b. Inadequate State and Local Programs

The Subcommittee reviewed the existing state and local programs relating to suicide prevention and discovered that they do not adequately address the state's high suicide rate. Although some services are provided through the facilities and programs of the Division of MHDS and various private and other public health care institutions, many of these services are focused on persons after they have attempted suicide and not on prevention prior to an incident.

At the first meeting of the Subcommittee, representatives of the Clark County Health District, the Nevada Public Health Foundation, and the Suicide Prevention Action Network USA (SPAN-USA) presented strong evidence of the need for state, local, and private sector involvement to address the lack of effective suicide prevention programs in Nevada, particularly in Clark County. Later in the course of the interim study, the Clark County Health District compiled and submitted a report that concludes, among other things, that there is a lack of coordination of the existing suicide prevention resources in Clark County. (See Appendix B, "An Initial Assessment of Suicide Prevention Resources and Services in Clark County.")

Throughout the study, the Subcommittee received testimony and correspondence concerning the need to provide increased mental health services statewide and particularly in Clark County and the rural counties. Testimony supported the need for increased mental health beds in Clark County to address the county's significant population of mentally ill homeless. Further testimony emphasized the need to provide additional state resources to fund mental health courts, establish mobile mental health crisis units, support rural mental health clinics, and provide treatment for persons with substance abuse and other co-occurring disorders. At two of the Subcommittee's meetings, there was extensive testimony concerning the relationship of suicide to substance abuse and other co-occurring disorders (dual diagnosis including various addictions and forms of mental illness).

At its meeting on February 1, 2002, the Subcommittee heard presentations from representatives of the clergy, law enforcement, emergency medical services, and fire service personnel regarding their education and training programs in suicide prevention and intervention. In addition, representatives of various health and mental health professional licensing boards in Nevada presented an overview of their education and training requirements in suicide prevention, intervention, and treatment. At its Reno meeting on March 22, 2002, a representative of the State Department of Education (SDOE) presented information on the current licensing requirements for Nevada teachers. Based on all these presentations, the Subcommittee concluded that these key professions are not currently receiving adequate education or training relating to suicide.

The Subcommittee's meetings on November 9, 2001, and March 22, 2002, included testimony regarding suicide prevention programs in Nevada's public schools. Representatives of the SDOE and the school districts in Clark and Washoe Counties testified on the current programs and services to pupils under their jurisdiction.

An education consultant with the SDOE admitted the need to improve suicide prevention programs in Nevada's schools. He briefed the Subcommittee on the results of the SDOE *Nevada Youth Risk Behavior Survey* (YRBS) administered to the middle and high school populations in the previous year. The consultant noted the following survey results for high school students: (1) nearly 30 percent of students experienced depression over a two week period which caused them to cease normal activity; (2) nearly 20 percent of students have seriously considered attempting suicide; (3) 16.4 percent of students have made a suicide plan; (4) nearly 11 percent of students attempted suicide one or more times; (5) nearly 4 percent of students that attempted suicide required medical intervention for injury, poisoning, or overdose; and (6) data can be cross-referenced to additional surveys to determine patterns with co-occurring conditions. The YRBS survey establishes a pattern within the school population, but it does not allow for intervention because the survey respondents are anonymous.

In his further testimony, the SDOE consultant revealed that there are very few references to suicide in the state's new Health Content Standards in health and physical education classes. He stated that the current requirements for suicide prevention education include the following: (1) pupils at grade 5 must define suicide and depression; (2) pupils at grade 5 must also explain the steps in obtaining assistance for a friend or family member who shows the warning signs of suicide; (3) pupils at grade 8 must list the warning signs of suicide; and (4) pupils at grade 12 must explain the steps in obtaining assistance for a friend or family member who shows the warning signs of suicide.

Representatives of the Clark County School District discussed their crisis response teams and other services to deal with suicide incidences and pupils at risk of suicide. A representative of the Washoe County School District noted that suicide prevention is an important part of the district's curriculum but that school personnel need additional information and training on suicide prevention. Based on the testimony from these school

district representatives and the SDOE staff, the Subcommittee concluded that school personnel need better education and training in suicide prevention and intervention. In addition, the Subcommittee recognized that the schools at all grade levels need additional staff resources -- particularly school counselors, school social workers, and school psychologists.

To illustrate the tragedy of suicide among Nevada's pupil population, selected newspaper articles relating to the recent suicide deaths of three children (one in Clark County, one in Douglas County, and one in Virginia City) are included in Appendix C.

In addition to receiving testimony about suicide among Nevada teenagers, almost every Subcommittee meeting included comments from senior citizens who pointed out the need for the state to address the high rate of suicide among the elderly population. At the Subcommittee's Reno meeting, two professors from the University of Nevada, Reno (UNR) presented evidence of a high rate of suicide in Nevada's rural counties and the need for the state to develop a suicide strategy that recognizes the unique culture of the rural communities. The prevalence of suicide attempts among Nevada's young Latinos, particularly Latinas, was described by another UNR professor and later by a school social worker. A mental health administrator for the Indian Health Services in Reno testified on the high rate of suicide among Native Americans (Indians) in Nevada, and he recommended the development of a statewide suicide prevention program with a significant focus on the Native American population.

Despite hearing much testimony about the inadequacy of existing services and programs, the Subcommittee received extensive information on two existing suicide prevention programs in Nevada that it judged to be good. One is the Crisis Call Center in Reno, which serves all of Nevada through its statewide suicide prevention hotline that is funded through the Division of MHDS. The Reno Crisis Call Center operates Nevada's only suicide prevention hotline certified by the American Association of Suicidology (AAS). The second program is the Yellow Ribbon Program in Douglas County, a community-based suicide prevention program coordinated by the Suicide Prevention Network of Douglas County. The Subcommittee decided that these and other model program elements should be incorporated into a statewide suicide prevention program

B. THE NATIONAL STRATEGY FOR SUICIDE PREVENTION

In recent years, there has been increased attention focused on suicide prevention at the national level. David Satcher, M.D., Ph.D., former Surgeon General of the United States, led the Federal Government's efforts to make America aware that suicide is a serious public health problem. The Surgeon General's national strategy has been adopted by many states and implemented through the development of state suicide prevention plans.

At the beginning of the interim study, Senator O'Connell, Chairwoman of the Subcommittee, asked the Subcommittee members and staff to review three important national reports relating to suicide prevention in the United States.

The first report is *The Surgeon General's Call to Action to Prevent Suicide 1999*. This is the Surgeon General's report that introduces a blueprint for addressing suicide—Awareness, Intervention, and Methodology, or AIM—an approach derived from a jointly sponsored national conference on suicide prevention convened in Reno in October of 1998.

The second report is *Suicide Prevention: Prevention Effectiveness and Evaluation*, a document released in 2001 by the Suicide Prevention Advocacy (Action) Network (SPAN-USA). The SPAN publication presents the organization's plan or visual model of its mission, and it explains important suicide prevention and evaluation concepts.

Finally, the third report, also released in 2001, is the Surgeon General's detailed plan following up on his 1999 report. It is *National Strategy for Suicide Prevention: Goals and Objectives for Action*, which recognizes suicide as a major public health problem and presents a national suicide prevention strategy with 11 goals and their related objectives for action. To make it easier to reference these goals, the *Summary* of this report was available to the Subcommittee members and the public at each Subcommittee meeting. The Surgeon General's goals (see Figure 2) served as the starting point of the Subcommittee's study of how best to address suicide prevention in Nevada.

Figure 2

National Strategy for Suicide Prevention: Goals and Objectives for Action
The Goals of the U.S. Surgeon General

1. Promote awareness that suicide is a public heath problem that is preventable;
2. Develop broad-based supports for suicide prevention;
3. Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse, and suicide prevention services;
4. Develop and implement suicide prevention programs;
5. Promote efforts to reduce access to lethal means and methods of self-harm;
6. Implement training for recognition of at-risk behavior and delivery of effective treatment;
7. Develop and promote effective clinical and professional practices;
8. Improve access to and community linkages with mental health and substance abuse services;
9. Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media;
10. Promote and support research on suicide and suicide prevention; and
11. Improve and Expand Surveillance Systems [2]

[2] *National Strategy for Suicide Prevention: Goals and Objectives for Action*, U.S. Department of Health and Human Services, Public Health Service, Rockville, Maryland, 2001, pp. 15-16.

At the Subcommittee's first meeting, Nevada's United States Senator Harry Reid, then the Assistant Majority Leader of the Senate, made (via videotape) a presentation outlining the suicide legislation in Congress (Senate Resolution 84, 105th Cong. [1997]), and his involvement with prioritizing suicide high on a national scale. Senator Reid mentioned the importance of the Surgeon General's national strategy, and he advocated the use of more education and suicide prevention programs on state and federal levels.

In Las Vegas on May 24, 2002, representatives of the National Conference of State Legislatures, SPAN-USA, the American Association of Suicidology, and the National Hopeline Network (1-800-SUICIDE) presented the Subcommittee with information on state suicide prevention plans and programs in other states. The founders of SPAN-USA testified concerning their efforts in developing the Georgia Suicide Prevention Plan, and they noted that many state plans, including Georgia's plan, incorporate the goals and objectives of the Surgeon General's national strategy. Appendix D contains "The Georgia Suicide Prevention Plan."

According to Davis C. Hayden, Ph.D., with the Psychology Department of Western Washington University, there are 18 states that have suicide prevention plans and all the remaining states are in the process of developing or considering developing such plans. The states identified by Dr. Hayden with existing plans include Colorado, Kansas, Louisiana, Maine, Minnesota, Missouri, Montana, Nebraska, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Tennessee, Virginia, Washington, and Wisconsin.[3]

III. SUBCOMMITTEE RECOMMENDATIONS

At its final meeting and work session on August 16, 2002, the Subcommittee adopted 19 recommendations under the topics of developing a state suicide prevention plan, improving local suicide prevention services, enhancing education and training for gatekeepers, addressing suicide prevention in the public schools, increasing state mental health services, and recognizing the relationship between suicide and co-occurring disorders. These proposals, which include four BDRs, are submitted for consideration by the 2003 Legislature. Appendix F contains the list of BDRs.

Organized by topic headings, the following sections of the report discuss the Subcommittee's recommendations.

[3] *State Plans for Suicide Prevention Web Page* (http://www.ac.wwu.edu/~hayden/spsp/right.html), by Davis C. Hayden, Ph.D., Psychology Department, Western Washington University, Bellingham, Washington, January 18, 2003.

A. NEVADA STATE SUICIDE PREVENTION PLAN AND PROGRAM

The Subcommittee spent a great amount of time and effort studying Nevada's suicide problem, particularly existing suicide prevention efforts in the state as compared with programs in other states and at the national level. As a result of the study, the Subcommittee concluded that suicide is one of the Nevada's most serious public health problems and, therefore, requires a comprehensive and statewide approach

Throughout the course of the study, mental health experts and citizens recommended that Nevada develop a State Suicide Prevention Plan and appoint personnel to develop and implement the plan. Suicide prevention advocates and various surviving family members suggested that Nevada's plan be modeled after existing state plans in Georgia and several other states, which incorporate goals from the United States Surgeon General's 2001 report, *National Strategy for Suicide Prevention: Goals and Objectives for Action*. See Appendix D, "The Georgia Suicide Prevention Plan."

The Subcommittee developed the position that Nevada should create a state plan that focuses primarily on the Surgeon General's goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who are the first contacts with individuals at risk of suicide. With the approval of the other Subcommittee members, Chairwoman O'Connell submitted a detailed proposal to Governor Kenny C. Guinn and the Director of the Department of Human Resources (DHR) to develop a state suicide prevention plan and program. Based on the cost estimates prepared by DHR fiscal staff, the program would cost $192,252 in Fiscal Year (FY) 2003-2004 and $170,426 in FY 2004-2005.

At its work session, the Subcommittee adopted the following recommendation, which reflects the proposal previously submitted to Governor Guinn and the DHR, to develop a state suicide prevention plan and establish a statewide program:

> **Draft and enact legislation requiring the development of a Nevada State Suicide Prevention Plan and establishing a Statewide Suicide Prevention Program within the Director's Office of Nevada's Department of Human Resources (DHR). The purpose of the state plan/program is to reduce the number of attempted and completed suicides in Nevada. The state plan should address the risk factors related to suicide and identify populations most at risk, and it should be distributed statewide and made available to the public not later than January 3, 2005.**
>
> **The State Suicide Prevention Plan shall be modeled after existing state plans in Georgia and several other states, which incorporate goals from the United States Surgeon General's 2001 report, *National Strategy for Suicide Prevention: Goals and Objectives for Action*. Nevada's state plan should focus on the Surgeon General's goals relating to public awareness, building community networks, and implementing suicide prevention training programs for law enforcement, health care professionals, school employees, and others who are the first contacts with individuals at risk of suicide.**

The Statewide Suicide Prevention Program will include the establishment and funding of two personnel positions to develop and implement suicide prevention programs in Nevada. One position would be the Statewide Suicide Prevention Coordinator based in the Director's Office of DHR in Carson City, and the other position would be a Suicide Prevention Trainer & Networking Facilitator based in the office of a government or nonprofit agency in Clark County. Funding for these positions may depend on a combination of government (federal, state, and local) and nongovernmental money. The Governor is urged to include this program as part of the DHR budget, and the Legislature is urged to approve a budget to support the program.

The Director of DHR shall be required to submit a copy of the state plan and a report on the program to the Governor and the Director of the Legislative Counsel Bureau (for distribution to the Legislature) on or before January 3, 2005.

Statewide Suicide Prevention Coordinator

Under the direction of the Director of DHR, the Statewide Suicide Prevention Coordinator will be responsible for developing, disseminating, and implementing a statewide suicide awareness and prevention plan and program throughout Nevada, including public education activities, gatekeeper training, and enhancement of crisis services. The Coordinator will conduct suicide prevention public awareness and media campaigns in all 17 Nevada counties, beginning first in Clark County.

Furthermore, the Coordinator will link suicide assessment and intervention trainers to schools, community centers, nursing homes, and other facilities serving persons most at risk of suicide. The position will coordinate the establishment of local advisory groups in each county to offer additional support to the program's efforts. Working with suicide prevention advocacy groups, community coalitions, managers of existing nationally accredited/certified crisis hotlines, and staff of mental health agencies in the state, the Coordinator will identify and address the barriers that interfere with providing services to at-risk groups, such as the elderly, Native Americans, youth, and residents of rural communities. The Coordinator will also develop and maintain a state suicide prevention Internet Web site with links to appropriate resource documents, accredited/certified suicide hotlines, licensed professionals, state and local mental health agencies, and national organizations.

The Coordinator will review current research on data collection for factors related to suicide, and develop recommendations for improved surveillance systems and uniform data collection. In addition, the position will develop and submit proposals for funding from federal government agencies and nongovernmental organizations. Finally, the Coordinator would provide oversight and technical assistance to the Suicide Prevention Trainer & Networking Facilitator based in Clark County.

Suicide Prevention Trainer & Networking Facilitator

Under the oversight of the Statewide Suicide Prevention Coordinator, the Suicide Prevention Trainer & Networking Facilitator will assist in disseminating and implementing the state suicide prevention plan and program in Clark County. This position will provide suicide prevention information and training to mental health agencies, social service agencies, churches, public health clinics, school districts, law enforcement agencies, emergency medical personnel, health care providers, and various community organizations. In addition, the position will assist in developing and carrying out public awareness and media campaigns targeting Clark County groups at risk of suicide.

The Trainer & Facilitator will assist in developing a network of community-based suicide prevention programs in Clark County, including the establishment of one or more local suicide prevention advisory groups. This position will facilitate sharing information and consensus building among multiple constituent groups in the county, including public agencies, community organizations, suicide prevention advocacy groups, mental health providers, and various representatives of the at-risk population groups.

(BDR 40--288)

B. LOCAL SUICIDE PREVENTION SERVICES

During the course of its study, the Subcommittee discovered that there is not a coordinated community suicide prevention program in Clark County. In addition, there is not a locally-based crisis center or suicide prevention hotline that is accredited or certified by a nationally recognized organization in the field of suicide prevention. Finally, there is a serious need in Clark County for a comprehensive suicide prevention program that includes a public awareness campaign, a community resource directory, and the delivery of appropriate services. Appendix B contains a memo, dated July 23, 2002, from Mike Bernstein, Health Educator II with the Clark County Health District, with an attachment, "An Initial Assessment of Suicide Prevention Resources and Services in Clark County."

Based on these findings, the Subcommittee voted unanimously to:

Urge, by drafting and adopting a resolution, governmental and nongovernmental agencies in Clark County to cooperate in establishing a Clark County suicide prevention program to provide effective and diverse suicide prevention programs for its communities. Funding for these programs should include a combination of government (federal, state, and local) and nongovernmental money. The proposed suicide prevention program would include the following:

- **Evidence-based programs to reduce risk factors and enhance protective factors for suicidal behavior across the life span of individuals;**

- **Distribution of awareness and educational materials to reduce the stigma associated with suicide;**

- **A 24-hour suicide hotline accredited or certified by a nationally recognized organization in the field of suicide prevention (and supported by a continuation and increase in the Clark County local governments' existing funding for suicide prevention programs);**

- **Service referral for at-risk individuals;**

- **Development of a Clark County Resource Directory and/or Internet Web site for suicide prevention and survivor assistance;**

- **Effective and accessible suicide intervention training for gatekeepers and first responders, including school district personnel;**

- **Media education and guideline distribution; and**

- **Suicide survivor services.**

(BDR R--289)

Representatives of the Clark County Health District testified at the Subcommittee's meetings on November 9, 2001, and May 24, 2002. They revealed that suicide prevention is one of the District's top priorities, and they recommended that the District be involved in public awareness campaigns and other suicide prevention efforts. In response to these recommendations, the Subcommittee voted in the affirmative to:

> **Urge, by drafting and adopting a resolution, that the Clark County Health District: (1) plan and coordinate a public information campaign on suicide prevention; and (2) expand community injury prevention efforts and increase the corresponding financial commitment. (BDR R--290)**

The Subcommittee discovered that there is a lack of public awareness of the seriousness of the suicide problem and a lack of coordination and communication between existing private and public agencies, particularly in communities in Clark County and many of the rural counties. To address this problem, the Subcommittee voted unanimously to:

> **Urge, by drafting and adopting a resolution, that each community in Nevada form a coalition of agencies and service providers to address suicide prevention, education, response, and treatment (adapted to community resources and needs), with the goals of reducing suicides in each community and providing survivor support. (BDR R--291)**

C. SUICIDE PREVENTION EDUCATION AND TRAINING FOR KEY GATEKEEPERS

The U.S. Surgeon General has identified the key gatekeepers in suicide prevention as those people who regularly come into contact with individuals or families in distress. Some examples of key gatekeepers are clergy, police officers, emergency medical personnel, primary health care providers, mental health professionals, and school personnel. Goal 6 in the Surgeon General's *National Strategy for Suicide Prevention: Goals and Objectives for Action* is to "Implement Training for Recognition of At-Risk Behavior and Delivery of Effective Treatment." At its meeting on February 1, 2002, the Subcommittee learned that most of the licensed health professions in Nevada have not received training to provide proper assessment, treatment, and management of suicidal patients, nor do they know how to refer clients properly for specialized assessment and treatment.

In response to the need for educating and training health professionals in suicide prevention, the Subcommittee voted unanimously to:

> **Include a statement in the Subcommittee's final report recommending enhancing community gatekeepers' education and training by requiring two hours of continuing education in suicide prevention, including identification, diagnosis, referral, and treatment, as a requirement for renewal of license for health care professionals.**

At its meetings on February 1 and May 24, 2002, the Subcommittee learned that emergency medical services (EMS) personnel play an important role in dealing with suicide victims and their families. However, the Subcommittee also learned that these key gatekeepers are not adequately trained to deal with suicide cases. In response, the Subcommittee adopted the following recommendation:

> **Include a statement in the Subcommittee's final report recommending that the DHR Health Division's Emergency Medical Services Program develop a formalized education and training program in suicide prevention for emergency medical services (EMS) managers and personnel. Among other things, the program should raise awareness of EMS personnel at risk for suicide. In addition, the program should provide EMS personnel with a directory of suicide prevention agencies and programs to leave at scenes of trauma.**

D. SUICIDE PREVENTION IN PUBLIC SCHOOLS

Although the Surgeon General has identified teachers and other educational staff as key gatekeepers in suicide prevention, the Subcommittee learned that teachers and other school personnel in Nevada currently are not receiving training to recognize pupils at risk of suicide and are not being trained in the appropriate interventions for suicidal persons. To address this situation, the Subcommittee voted to:

Draft and send a letter to the Legislative Committee on Education recommending that it consider requesting legislation requiring all public school teachers, including elementary education teachers, to complete certain courses in suicide prevention prior to license renewal. Such legislation could require that Nevada's Regional Training Programs for the Professional Development of Teachers and Administrators provide teachers and administrators with information and training specific to suicide issues, including identifying and intervening with pupils at high risk of suicide.

At its meeting in Las Vegas on May 24, 2002, the Subcommittee learned that more funding is needed for counseling positions in Nevada's public schools because the current ratios of students to counselors are 400 to 1 in high school and 500 to 1 in middle school. Testimony also indicated that there are no state funds for counselors at the elementary school level. Furthermore, the testimony noted the important role of school counselors regarding suicide prevention, intervention, and treatment. In response to this testimony, the Subcommittee voted to:

Draft and send a letter to the Legislative Committee on Education requesting that it consider requesting legislation for an appropriation of state funds to provide additional counseling positions in public middle schools and high schools, and state funds for counselors at the elementary school level.

At the meeting in Reno on March 22, 2002, a school social worker who directs a family resource center presented the Subcommittee with a model for adolescent suicide prevention. She suggested that all Nevada school districts be encouraged to adopt this model, which is partly based on a program used in the Washoe County School District. The Subcommittee agreed with this suggestion and adopted the following recommendation:

Include a statement in the Subcommittee's final report recommending that Nevada school districts address adolescent suicide by adherence to a theoretical framework which incorporates three levels of intervention: (1) primary intervention – when a suicide occurs; (2) secondary intervention – treatment activity with survivors, other students, parents, school personnel, and so forth; and (3) tertiary intervention – suicide prevention activities and programs.

In addition, recommend that the school districts consider hiring additional trained professionals, including counselors, school psychologists, and social workers, to: (1) conduct assessments, implementation, follow-up, and to provide treatment (including primary, secondary, and tertiary interventions); (2) perform interventions in school settings; (3) establish relationships with parents, students, and other professionals; (4) maintain effective networks with the community; (5) address the mental health of troubled students; and (6) support the school student services staff.

E. STATE SUPPORT FOR SUICIDE PREVENTION AND MENTAL HEALTH SERVICES

Throughout the study, the Subcommittee heard various witnesses testify regarding the need to increase the availability of mental health services statewide. There was a particular emphasis on the need to increase funding for rural mental health clinics and for additional mental health beds in Clark County.

Recognizing the relationship of mental health services to suicide prevention, the Subcommittee voted in the affirmative to:

> **Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues recommending consideration of requesting that the Governor and the Legislature approve increased funding for mental health services throughout Nevada and particularly for rural mental health agencies to provide emergency response and ongoing services to suicide survivors, those who have attempted or threatened suicide, and those determined to be at high risk for suicide.**

At the Subcommittee's meeting in Las Vegas on May 24, 2002, representatives of the Las Vegas Metropolitan Police Department (Metro) testified concerning the serious need for additional mental health beds to deal with the mentally ill homeless population in Clark County. Following up on this testimony, the Metro budget staff submitted specific recommendations developed by the Task Force on Emergency Room Overcrowding (also know as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition. Recognizing that this issue should be brought to the attention of the appropriate ongoing statutory committees, the Subcommittee voted in the affirmative to:

> **Draft and send letters to the Legislative Committee on Health Care and its Subcommittee to Study Mental Health Issues requesting consideration of the following recommendations from the Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition:**
>
> - **Allow more people in crisis to have access to treatment and allow first responders, police, fire, and paramedics, a timely return to service by: (1) creating a centralized drop-off location for triage with funding provided by state and local governments and area hospitals; (2) developing a mechanism for providing permanent, long-term funding to support CPI and mental health services such as increasing the tax on the sale of liquor; (3) considering changing NRS 433A.330, which requires the mentally ill to be transported to hospitals for medical screening or authorize paramedics to transport patients, who meet specific criteria, directly to a MHDS facility or other qualified facilities for treatment; and (4) funding mobile crisis units that can make**

assessments in the field and reduce the need for transporting patients to hospitals.

- **Increase services to the seriously mentally ill in southern Nevada by (1) adding sufficient crisis observation beds and adequate staff to care for the increasing number of patients who need mental health care, including those with co-occurring disorders; (2) adding sufficient in-patient beds and staffing for treatment after patients have been assessed and stabilized at a triage facility, emergency room, or MHDS facility; (3) establishing a client data base to provide easy access to available services, track patients through various programs and prevent duplication of services; (4) providing centralized and coordinated case management and outpatient services; (5) contracting with the Program for Assertive Community Treatment to perform personalized, intensive case management; and (6) ensuring that all possible federal funding has been accessed.**

- **Establish and fund a mental health court in southern Nevada.**

The letters from the Subcommittee should also include a statement in support of providing funding for mental health courts in northern Nevada and throughout the state.

At the Subcommittee's meeting in Reno on March 22, 2002, testimony indicated that the Division of MHDS is not collecting data to determine the number of its clients who have recovered from suicidal ideations versus the number who later completed suicide. Testimony also indicated that data is not gathered on the incidence of suicide among family members of MHDS clients. Carlos Brandenburg, Ph.D., Administrator of the Division of MHDS, stated that his Division needs upgraded computer technology in order to collect vital suicide statistics. In response to this information, the Subcommittee voted to:

Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature approve the necessary state funding to provide Nevada's Division of Mental Health and Developmental Services (MHDS) with the computer equipment and related software necessary to collect and analyze data regarding suicide rates for MHDS clients and their family members.

The Reno Crisis Call Center is the only nationally certified crisis center in Nevada, and it also operates the statewide suicide prevention hotline. Although the statewide hotline currently serves residents in Clark County, the Reno Crisis Call Center recognizes the need to expand its services to include a crisis call center actually located in Clark County. In response to a suggestions made by suicide prevention advocates, the Subcommittee agreed to:

Include a statement in the Subcommittee's final report recommending that the Governor and the Legislature support state funding for the Reno Crisis Call Center to establish, in Clark County, a service similar to its existing crisis call center and suicide prevention hotline.

To meet the needs of providing suicide prevention services in Clark County, the Clark County Community Organizer for SPAN-USA and a representative of the Psychology Department at the University of Nevada, Las Vegas (UNLV) advised the Subcommittee that they had discussed arranging for psychology faculty and students to assist in providing suicide prevention services in Clark County. Although the Psychology Department at UNLV was the only department to develop a specific proposal in cooperation with SPAN-USA, the Subcommittee recognized that other departments at UNLV, such as counseling and social work, may also be interested in developing a proposal to provide suicide prevention services in the community. In response to suggestions made by suicide prevention advocates, the Subcommittee agreed to:

Include a statement in the Subcommittee's final report recommending that the Board of Regents of the University and Community College System of Nevada (UCCSN), the UCCSN Chancellor, and the President of the University of Nevada, Las Vegas (UNLV) assist in providing university faculty, staff, and students to help coordinate and staff suicide prevention programs in Clark County.

One possible plan would be to coordinate educational, survivor support, and crisis line services through the Psychology Department at UNLV. A faculty member could serve in a coordinating role, responsible for overseeing the various support programs and supervising graduate students who would provide direct services. Services provided by graduate students could include educational programming for gatekeepers, at-risk groups and concerned community members, support groups for survivors, and coverage for the suicide crisis line. Additionally, graduate students could recruit volunteers from the community and from the undergraduate psychology program who would be trained to provide crisis intervention services and would assist with the crisis line work. Crisis line training and coverage would be specifically developed to meet accreditation/certification requirements with a short-term goal of obtaining crisis line accreditation/certification. This plan would provide continuity of preventative and intervention services as well as provide long-term stability in the delivery of ongoing services.

In recognition of the efforts of President George W. Bush's Commission on Mental Health, Senator Townsend, a member of the Commission, and Chairwoman O'Connell suggested that the Subcommittee support the work of the Commission, particularly any of its recommendations concerning suicide prevention. The Subcommittee voted to:

Include a statement in the Subcommittee's final report supporting the work of the President's New Freedom Commission on Mental Health. Also include in the final report a summary of the Commission's findings and recommendations regarding suicide prevention.

Appendix E contains the Suicide Prevention Subcommittee's draft report, including findings and policy options, of the President's New Freedom Commission on Mental Health.[4]

F. SUBSTANCE ABUSE AND OTHER CO-OCCURRING DISORDERS

At the Subcommittee's meeting on March 22, 2002, a representative of Mothers Against Drunk Driving (MADD) presented research suggesting that teenagers who abuse drugs or alcohol are more likely to progress from thinking of suicide to actually attempting suicide. Stating that Nevada has an extremely high alcohol usage rate among its youth, she recommended legislation to close a loophole in the current statute regarding alcohol use and possession by minors. In response to this concern, the Subcommittee voted in the affirmative to:

> **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of requesting legislation to amend the statutes pertaining to minors and alcohol. Although current law makes it unlawful for a minor to be purchasing, consuming, or possessing an alcoholic beverage, testimony indicated that law enforcement cannot arrest minors who have already consumed, but are not at the time consuming, an alcoholic beverage. Amend the statutes with provisions similar to the Reno Municipal Code whereby it is unlawful for a person under the age of 21 to "be impaired to any degree by the use of an alcoholic beverage." The purpose of this amendment is to require that such minors be required to undergo evaluation and possible treatment for alcohol and/or drug abuse.**

As previously stated, representatives of Metro testified about the serious need for additional mental health beds to deal with the mentally ill homeless population in Clark County and submitted recommendations developed by the Task Force on Emergency Room Overcrowding (also known as CPI Task Force) and the Southern Nevada Mental Health Coalition. One of those recommendations was to expand the civil protective statute from its existing provisions concerning persons with alcohol abuse to add provisions for persons with substance abuse and mental illness. Because the Subcommittee decided that this issue should be referred to the Standing Committees on Judiciary, it voted in the affirmative to:

> **Draft and send letters to the Legislature's Standing Committees on Judiciary recommending their consideration of the recommendation from the Task Force on Emergency Room Overcrowding (also known as the Chronic Public Inebriate [CPI] Task Force) and the Southern Nevada Mental Health Coalition requesting legislation to expand the civil protective custody statute (NRS 458.270) to pertain to persons with substance abuse and mental illness.**

At its meetings on March 22 and May 24, 2002, the Subcommittee heard extensive testimony concerning the link between suicide and substance abuse and other co-occurring disorders. The

[4] "An Outline for the Draft Report of the Subcommittee on Suicide Prevention," President's New Freedom Commission on Mental Health, December 3, 2002.

testimony indicated that suicide prevention plans and programs should address this link. In response to these expressed concerns, the Subcommittee voted in the affirmative to:

> **Include a statement in the Subcommittee's final report recognizing the importance of including substance abuse and other co-occurring disorders in a Nevada statewide suicide prevention plan. In addition, the statement should recognize that the enhancement of the delivery of co-occurring treatment and services may assist in reducing Nevada's suicide rate.**

As previously mentioned, a representative of MADD presented the Subcommittee with references to research suggesting that teenagers who abuse drugs or alcohol are more likely to progress from thinking of suicide to actually attempting suicide. To further address this issue, the Subcommittee voted in the affirmative to:

> **Include a statement in the Subcommittee's final report recognizing that any state suicide prevention program should address the relationship between youth suicide and the use of alcohol and drugs by minors.**

IV. SELECTED REFERENCES AND RESOURCES

Publications

"An Initial Assessment of Suicide Prevention Resources and Services in Clark County," by Mike Bernstein, Health Educator II, Clark County Health District, July 23, 2002.

"An Outline for the Draft Report of the Subcommittee on Suicide Prevention," President's New Freedom Committee on Mental Health, December 3, 2002.

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"Rate, Number, and Ranking of Suicide for Each U.S.A. State, 2000," published by the American Association of Suicidology, Washington, D.C., September 21, 2002.

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"Effects of Exercise Training on Older Patients With Major Depression," reprinted from the *Archives of Internal Medicine*, October 25, 1999, Volume 159, Copyright 1999, American Medical Association, presented by Glen Martin, Volunteer, Retired Senior Volunteer Program, and Member/Representative, American Association of Retired Persons, Carson City, Nevada.

"Suicide in Nevada's Hinterlands: A Cultural Perspective," by Marie I. Boutté, Ph.D., Department of Anthropology, University of Nevada, Reno, Nevada. Manuscript published in *Disease and Medical Care in the Mountain West: Essays on Region, History, and Practice*. Edited by Martha L. Hildreth and Bruce T. Moran. University of Nevada Press, 1998.

State Plans for Suicide Prevention Web Page (http://www.ac.wwu.edu/~hayden/spsp/right.html), by Davis C. Hayden, Ph.D., Psychology Department, Western Washington University, Bellingham, Washington, January 18, 2003

"Violent Acts of Sadness: The Tragedy of Youth Suicide," by Julie Thomerson, ***State Legislatures***, National Conference of State Legislatures, May 2002, pages 30-34.

Reducing Suicide: A National Imperative, SK Goldsmith, TC Pellmar, AM Kleinman, WE Bunney, editors. Committee on Pathophysiology & Prevention of Adolescent & Adult Suicide, Board on Neuroscience and Behavioral Health, Institute of Medicine, published by National Academy Press, Washington, D.C., 2002.

"Substance Use and the Risk of Suicide Among Youths," The National Household Survey on Drug Abuse (NHSDA) Report, Office of Applied Studies, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, July 12, 2002.

"The Georgia Suicide Prevention Plan," prepared by Julie W. Chambliss, Ph.D., Suicide Prevention Advocacy Network (SPAN), Marietta, Georgia, June 30, 2001.

Organizations and Contact Persons

Linda L. Flatt, Nevada Community Organizer, Suicide Prevention Action Network USA (SPAN-USA), Henderson, Nevada. Internet Web site: http://survivingsuicide.com.

Suicide Prevention Research Center, Las Vegas, Nevada (702-671-2338).

SPAN-USA. Internet Web site: www.spanusa.org.

Misty Allen, Crisis Line Coordinator, Crisis Call Center, Reno, Nevada (1-877-885-HOPE [4673]). Internet Web site: www.crisiscallcenter.org.

American Foundation for Suicide Prevention. Internet Web site: www.afsp.org.

American Foundation for Suicide Prevention Nevada Chapter. Internet Web site: www.afspnv.org.

Sue Eastgard, Director, Washington State Youth Suicide Prevention Program. Internet Web site: www.yspp.org.

Yellow Ribbon Suicide Prevention Program. Internet Web site: www.yellowribbon.org.

American Association of Suicidology. Internet Web site: www.suicidology.org.

Marian Thomas, Trauma Intervention Programs (TIP) of Southern Nevada, Las Vegas (702-459-1055). Internet Web site: www.tipnational.org.

Reese Butler, Executive Director, Kristin Brooks Hope Center, and Administrator, The National Hopeline Network 1-800-SUICIDE, Purcellville, Virginia. Internet Web site: www.hopeline.com.

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Suggested Legislation

BDR 40-288	Creates Statewide Program for Suicide Prevention within Department of Human Resources.
BDR R-289	Urges agencies in Clark County to cooperate in establishment of plan for suicide prevention in Clark County.
BDR R-290	Urges Clark County Health District to plan and coordinate public information campaign relating to suicide prevention and expand injury prevention efforts in Clark County.
BDR R-291	Urges each community in Nevada to form coalition of agencies and service providers to reduce number of suicides and provide support for survivors.